

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

33923

State File No. ....

333

3074

Registrar's No. 189

BIRTH NO. <u>37022</u>		REG. DIST. NO. ....		PRIMARY REG. DIST. NO. ....		State File No. ....	
1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>		c. LENGTH OF STAY (In this place) <u>3 Hours</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>East Prairie</u>		<u>0670</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>Star Route</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Michael</u> b. (Middle) <u>O</u> c. (Last) <u>Starr</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>9-21-1952</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Child</u>		8. DATE OF BIRTH <u>6-20-1952</u>	
9. AGE (In years last birthday) <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		11. BIRTHPLACE (State or foreign country) <u>East Prairie, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		14. NAME OF HUSBAND OR WIFE <u>—</u>			
13a. FATHER'S NAME <u>Harry Lee Starr</u>		13b. MOTHER'S MAIDEN NAME <u>Edna McMikns</u>		14. NAME OF HUSBAND OR WIFE <u>—</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>HARRY LEE STARR EAST PRAIRIE, MO</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acidosis, Metabolic</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Diarrhea, Infections</u> DUE TO (c) <u>—</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs.</u> <u>10 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>5710</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>—</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-21</u> , 19 <u>52</u> , to <u>9-21</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>9-21</u> , 19 <u>52</u> , and that death occurred at <u>7:00 P.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Ed. Martin</u> (Degree or title) <u>—</u>		23b. ADDRESS <u>Sikeston, MO</u>		23c. DATE SIGNED <u>9-24-52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>9-22-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MOONBDS</u>		24d. LOCATION (City, town, or county) (State) <u>NEW MADRID MO</u>	
DATE REC'D BY LOCAL REG. <u>9-27-52</u>		REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>RICHARDS NEW MADRID, MO</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED SEP 29 1952  
SCOTT COUNTY HEALTH CENTER  
CO. FILE NO. 952-281

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed *Raymond Wilson*

Licensed Embalmer No. *4384*

P. O. Address *New Madrid, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.